Statement of: Chief Superintendent Jonathan George JAMES

Dated: 12th July 2004

Introduction

This statement is provided in response to a regulation 9 notice served upon me by ACC Cole on the 5th April 2004. That notice details 9 allegations in relation to my conduct when Senior Investigating Officer for Operation Rochester. These allegations are in addition to those contained in a Regulation 9 notice served upon me by Chief Superintendent Clacher on the 22nd May 2002.

It is my understanding that the allegations in the notice of the 5th April 2004 are directly drawn from a report by Detective Chief Superintendent Johnston of Avon and Somerset Constabulary who was instructed by the Police Complaints Authority to review Operation Rochester.

I have been provided with a copy of that report dated the 2nd February 2004 and invited to respond to the allegations in the regulation 9 notice and a number of specific questions identified in Detective Chief Superintendent Johnston's report. In preparing this statement I have assumed that there is no other material which would have assisted me in providing a full response to these matters.

In providing a response this statement deals with each numbered paragraph of Detective Chief Superintendent Johnston's report in turn. The statement does not provide a specific further response to the allegations in the regulation 9 notice of the 5th April 2004 as those allegations appear to reflect observations in the Johnston report.

In responding to the matters raised I have included extracts, clearly italicised in blue, from my previous statement of the 31st January 2003. There are references in this statement to other specific areas of that statement where appropriate.

Commentary on Introduction and Background

Paragraphs 1 to 11 of the report provide background information in respect of which I have no observations excepting in relation to paragraphs 5, 6 and 10 which make references to a Mrs Fitzgerald. I assume that this is an error and the paragraphs should refer to Mrs Mackenzie.

Commentary on Methodology

Paragraphs 12 to 18 detail the methodology for the review undertaken by Detective Chief Superintendent Johnston. I note that the current enquiry team and the current SIO, Detective Chief Superintendent Watts, provided a briefing. I further note that the reviewing officer states, in paragraph 15,

"it would not be possible to read and assimilate all the detail within the volumes".

This being a reference to material produced over a number of years.

I would observe that none of those who briefed the reviewing officer had any detailed knowledge of the enquiries conducted during my tenure as SIO. There is no indication that any attempt was made to speak to any of the officers who were intimately associated with that investigation including DCI Paul Clark, DI Ashworth or Code A Neither was there apparently any attempt to discuss the investigation I conducted with my then immediate line managers, DCS Watts or ACC SO Smith.

I am also concerned to note there was apparently no attempt to discuss the investigation with any person from the Commission for Health Improvement with whom I had a close working relationship from July 2001 to March 2002.

I would also observe that it is my understanding that the current Rochester investigation arises from information that was made available to the Force after the 28th January 2002 and therefore after the critical decision making I was

involved with during my tenure as SIO.

Commentary on the Findings

Paragraph 19 refers to policy that appears to be written by DCI Burt. This paragraph makes no reference to dates and it does not correlate with copies of the SIO's Policy book I have had access to. It therefore follows that the question posed in paragraph 20 should be directed to Mr Burt.

Paragraphs 20 and 21 refer to observations about DCI Burt's policy book during his tenure as Senior Investigating Officer.

Paragraph 22 poses a specific question concerning whether or not I received a complete policy book from DCI Burt on taking control of the investigation. I did receive complete policy books at the appropriate time and, to the best of my recollection, this was on or about the 21st May 2001.

I had no reason to doubt the integrity of those documents upon receipt. I did not consider that the attachment of explanatory notes to pages of the policy book was unusual. This was a relatively common practice amongst SIO's in the force at that time.

Paragraphs 23 to 26 appear to be a series of observations about policy issues when DCI Burt was the SIO. I am unable to provide any commentary on the specific questions raised in Para 23 which are matters clearly concerning Mr Burt.

Paragraph 27 raises specific questions inviting my comments. The multiple question is:

"What was Supt James' view on the replacement of DCI Burt, was it due to his imminent retirement? Or was it due to his protestations over the apparent refusal of others to widen the investigation?"

The replacement of DCI Burt was, to the best of my knowledge, a straightforward management decision that preceded my appointment to the major crime team at Fratton. To the best of my recollection DCI Burt had moved posts about the beginning of May 2001 to a headquarters based policy function. I am not aware of the rationale behind his posting, I had returned to the force from a 12 month career break on the 1st May 2001, but I have no reason to believe that is was connected with any issues about the scope of the Rochester investigation.

At the time that I returned to the force on the 1st May it was the position that DCI Burt's SIO casework was being transferred to others. One of those enquires was Operation Rochester. This position is articulated clearly in my statement of the 31st January 2003 at page 4. The relevant section is reproduced below.

I should point out it is my recollection I had no knowledge of Operation ROCHESTER from the time in which it commenced in August 1999 until May of 2001. Indeed between May 2000 and April 2001 I was on unpaid leave from the Constabulary. I returned from unpaid leave on the 1st of May, 2001, and took up a position as one of the two Senior SIO's on the Force Major Crime Team based at Fratton. Within a few days of taking up that post I had a series of short conversations with DCI BURT about the ROCHESTER investigation. At that stage DCI BURT had taken up a position as the Detective Chief Inspector at Headquarters and it was apparent during our brief conversations that it was no longer appropriate for him to continue with the investigation and that it needed to be managed within the framework of the Major Crime Team.

The second part of the question at paragraph 27 refers to:

"his protestations over the apparent refusal of others to widen the investigation".

I was aware that DCI Burt had views about widening the scope of the investigation. This is explicitly referred to in my statement of the 31st January 2003 at page 2 where there is reference to a meeting on the 12th April 2000 and at page 3 another reference to a review of policy on the 14th April 2001 with a view to widening the scope of the enquiry.

As far as I was aware DCI Burt's views on widening the scope of the enquiry were not connected to his transfer to HQ. However the decision to post him from the major crime department predated my return to force and was not my responsibility.

I assume that former Detective Chief Superintendent Akerman will be able to assist in this matter.

I am concerned that the language used to pose a question about DCI Burt's position as SIO lacks objectivity. The phrase:

"or was it due to his protestations over the apparent refusal of others to widen the investigation"

is not neutrally expressed. DCI Burt had a view about widening the investigation that he presented to others but this was rejected. This is described in my previous statement at page 2 and is reproduced below for ease of reference.

On the 12th of April, 2000, DCI BURT initiated a briefing meeting at Netley to various individuals which included the then Head of CID Detective Chief Superintendent AKERMAN. DCI BURT sought to extend the investigation in the following terms:

- *Research and investigate other cases involving similar pattern of medical conduct*
- *Research and investigate process for certifying deaths*
- *Finalise RICHARDS investigations*

It is clear from notes available from this meeting that DCI BURT was given limited approval to proceed. He was directed to focus on the RICHARDS case at that time and to use this as a benchmark for other cases once that investigation had been concluded.

The language used to frame the question in the report of Detective Chief Superintendent Johnston, without having determined from DCI Burt if he was "protesting" about the "refusal of others to widen the investigation", is in my submission highly suggestive of senior managers in the organisation acting to frustrate the enquiry. It is not my belief that this was the case and I would not have played any part in such a course of conduct.

Paragraph 28 raises a specific question about a separate corporate decision making forum which must relate to the period when DCI Burt was the SIO. It therefore follows that I cannot comment on this matter. It predates the period when I was the SIO and refers to a period when I was not employed in the organisation.

Paragraph 29 raises a further specific question concerning DCI Burt's position as SIO and his perceived frustrations. This again is again a matter for DCI Burt.

Paragraphs 30 to 32 make observations across a range of areas concerning DCI Burt's tenure as SIO. These matters are clearly for him to provide an appropriate response. I note that at paragraph 32 there is further reference to the Fitzgerald's. I assume that this is a mistake and that the report should refer to Mrs Gillian Mackenzie.

Paragraph 33 states that a further 10 families contacted the police in April 2001 to make complaints relating to the death of a relative. This statement does not accurately reflect the position.

Following the publication of an article in the Portsmouth Evening News on the 3rd April 2001 a number of people contacted the police expressing general concerns about the standard of care a named relative received whilst an in-patient at Gosport War Memorial Hospital. DCI Burt was made aware that the article was to be published and made arrangements to brief staff who might receive calls from members of the public who responded to the article by contacting the police.

DCI Burt concluded that it would not be appropriate to engage those making contact with the police after having read the article.

My statement of the 31st January describes his decision making.

On the 3rd of April, 2001, DCI BURT recorded that the investigation into the death of Gladys RICHARDS at Gosport War Memorial Hospital was subject of front page coverage in the Portsmouth Evening News. A global e-mail advised staff how to respond to any potential contact from members of the public also expressing concerns about other deaths at Gosport War Memorial Hospital. It should be noted that this was the first front page story and the reporting indicated that up to 600 other deaths might be investigated.

On the 14th of April, 2001, DCI BURT reported that five other persons have reported concerns about patient deaths at Gosport War Memorial Hospital. He also indicated that a previous member of staff at the hospital, Pauline SPILKA who had been employed as a Nursing Auxiliary, had also been seen as a result of concerns that she had raised and that a statement had been obtained from her. He advised that these developments required a review of the previous policy.

On the 23rd of April, 2001, DCI BURT recorded that each caller to date had been told that their details would be noted and that an officer would visit them in due course to explore more fully the concerns that they had expressed about other patient care at Gosport War Memorial Hospital. He confirmed that this was in accordance with the 'on hold' policy pending the outcome of the Crown Prosecution Service decision in the RICHARDS case.

On the 12th of May, 2001 DCI BURT in an e-mail to me emphasised that the agreed policy of awaiting the outcome of the decision of the CPS in relation to the Gladys RICHARDS case was based on the fact that a single isolated allegation had been made and that any speculative and intrusive investigation of other cases would be more effectively justified if proceedings arose from the RICHARDS case. This remark is made in the context of the need to review that

position, given that other people have made contact with the Police expressing concerns about deaths at the hospital and that a statement had been obtained from Pauline SPILKA. This seemed to me to be an entirely rational and objective position given my limited knowledge of the investigation at that time.

DCI Burt clearly considered that the decision not to investigate further at that time was in accordance with policy agreed with senior managers. It is my clear understanding that this decision was the outcome of the meetings of the 12th April and 10th July 2000 which are described in my previous statement in the following terms:

On the 12th of April, 2000, DCI BURT initiated a briefing meeting at Netley to various individuals which included the then Head of CID Detective Chief Superintendent AKERMAN. DCI BURT sought to extend the investigation in the following terms:

- *Research and investigate other cases involving similar pattern of medical conduct*
- *Research and investigate process for certifying deaths*
- *Finalise RICHARDS investigations*

It is clear from notes available from this meeting that DCI BURT was given limited approval to proceed. He was directed to focus on the RICHARDS case at that time and to use this as a benchmark for other cases once that investigation had been concluded.

On the 10th of July, 2000, a progress update report completed by DCI BURT indicates that Detective Chief Superintendent AKERMAN approved the work completed to date i.e. focusing on the RICHARDS case with some background into the other cases also completed. It is clear from the papers that at that time the enquiry relied exclusively for expert evidence on a report commissioned from Professor Brian LIVESLEY'S which I shall deal with at a later stage in this statement.

I should point out that the initial decisions in respect of those further "complaints" were made before I undertook the SIO function for Operation Rochester.

Nevertheless those decisions, and the supporting rationale, were part of the briefing I received from DCI Burt. I saw no grounds at the time I assumed the responsibility as SIO to contradict those decisions which it was clear were supported, if not in fact determined by the Head of CID.

In support of my position to concur with the decision of DCI Burt I would submit that there is a very clear distinction between making a specific complaint of criminal conduct relating to a death in a hospital setting and making a complaint about the general standard of care a patient received. This is particularly the case where those "complaints" were prompted by ill informed and inaccurate reporting in a local newspaper.

It was my clear understanding that it was the general issue of care that was being raised by these further 'complaints' not that the standard of care or an act or omission by a member of medical staff had led directly to death. When I was variously briefed by DCI Burt and others between the 1st May and 21st May 2001 I was not given to understand that the nature of the complaints amounted to a clear allegation of unlawful killing by medical staff at Gosport Ware Memorial Hospital.

This is not simply a question of semantics. It is a matter of clarity that is particularly relevant given the nature of the investigation into my alleged misconduct.

It should also be noted that the police received calls from members of the public praising care at the Hospital. Arguably therefore there was a need for some balance in determining at that stage an appropriate police response.

I would further observe that in making choices about the course and conduct of the enquiry, and the application of appropriate resources, I was endeavouring to

make objective evidence based decisions. I was resisting the temptation to make decisions based on assumptions.

Whilst it is entirely appropriate for SIO's to develop and test hypotheses in the course of managing enquiries it was not my judgement that there was a body of reliable information on which rational hypotheses could be properly constructed to be tested in an investigative context.

Paragraph 34 makes observations about the scope of the enquiry and refers to specific policing decisions. I am unable to understand the point that is being made in the report. It is not clear to me what action, if any, is being referred to and what, if any impact, these issues have in the later findings section of the report.

Paragraph 35 refers to a significant shift to incorporate an extension of the scope of the enquiry that does relate to the period when I was the SIO. Although the report is not explicit at this point I assume it refers to policy decision number 2 dated the 21st May 2001. This policy has a specific context that is not acknowledged in the report but which is articulated in my statement of the 31st January 2003. That very full context may be found at pages 4 to 7 of that statement.

I particularly draw attention to the issues that were subject of discussion at a meeting on the 21st May 2001, the date I assumed responsibly as SIO. I reproduce a section of my statement below for ease of reference.

Consequently I initiated a briefing meeting with the Assistant Chief Constable Special Operations, with a number of other key staff to be conducted on the 21st of May, 2001, at the Major Incident Complex at Fratton Police Station. That meeting subsequently took place at 1800 hours that day and among the persons present were DCI BURT, DCI CLARK, DI ASHWORTH, Code A *, ACC Specialist Operations and Mr. Mike WOODFORD the Force Solicitor.*

I had already decided before this meeting had been convened that this would be the appropriate point at which to effect a change of SIO between DCI BURT and myself whatever the outcome of that meeting in terms of the future conduct of the investigation. I felt the potential issues about the nature, conduct and impact of the investigation demanded that the role of SIO be discharged by somebody of my rank within the organisation.

At the meeting of the 21st of May, there was considerable discussion about the potential future direction of the enquiry. The debate effectively hinged on whether or not the developments I have previously described i.e. contact from other persons expressing concerns about other deaths at Gosport War Memorial Hospital and the statement of Pauline SPILKA constituted such significant new information as to justify moving the enquiry into a much more extended phase.

I made it clear at that meeting, and it was generally accepted by the others present, that an extension of that enquiry did not mean merely focusing upon those persons who had contacted the Police to express concerns but should be focused upon the very significant number of other deaths that Doctor BARTON had certified at the hospital. Further that there was a need to develop a very clear, focused, rational and objective review process for examining each of those deaths to determine whether or not any of them should be investigated in order to identify whether or not any person involved in the care of those patients was criminally liable. It was my judgement that such a decision could not be taken by DCI BURT or myself. Firstly because there had been a previous direction that the outcome of the RICHARDS case and the CPS decision making should be used as a benchmark in relation to extending the scope and scale of the investigation. Secondly because the potential scope of the investigation was such that applying resources was a matter that should be determined and sanctioned by either the Head of CID or the Assistant Chief Constable Special Operations. Thirdly that the scope of such an investigation and its potential public and institutional implications meant that such decision making should be endorsed to the level I have indicated. At the conclusion of the meeting a number of key decisions were made:

- *That the investigation should not be extended at this stage but that the principles that applied to the previous decision making, particularly the outcome of the CPS decision in respect of the RICHARDS case, should be awaited with a view to then reviewing the position.*
- *That the position in relation to Professor LIVESLEY'S report and unequivocal conclusions, which at that stage were the only expert evidence available on which critical decisions could be made, needed to be reviewed in order for us to determine the extent to which they could be relied upon as a guide to extend the scope and scale of the enquiry.*
- *That some scoping work needed to be completed to understand how the investigation might be managed if it were to be extended in the manner that I have described.*
- *Further, the extent to which other agencies or authorities might have some responsibility for leading the investigation should be explored. Specifically this meant whether or not there was a role for agencies of the National Health Service, the UKCC or the GMC.*

I think that it is important to note that the list of attendees at the meeting includes the force solicitor, Mr Woodford. This meeting was conducting business about an important enquiry in an open and transparent manner utilising key personnel from across the organisation to add value to the outcome.

Indeed from the beginning of my tenure as SIO for the investigation I was concerned to ensure that the widest potential implications of the enquiry were brought out into the open and properly discussed.

I believe this demonstrates that rather than seeking to "sweep the matter under the carpet" I was actively engaging myself in developing proposals and options for the future direction of the enquiry.

Amongst the issues discussed at the meeting of the 21st May was the potential future scope of the enquiry and it was made clear that, if Professor Livesley was a reliable source of information and opinion, it might be necessary to review up to 600 deaths at Gosport War Memorial Hospital.

The key decisions made at that meeting are as recorded in my statement. I am confident that, if they are asked, the other persons in attendance will be able to confirm the issues discussed and the decisions.

The section that I have underlined clearly articulates one of the key purposes of the meeting and it refers specifically to the decision to extend the scope of the original Rochester investigation beyond the only case at that time being considered, namely the death of Gladys Richards.

I submit that it is also crucial in understanding the sequence of events during my tenure as SIO for Operation Rochester to articulate the constraints on the autonomy of SIO's in the force at the time. Whilst there was a major crime team in place at that time it was extremely limited in numbers and therefore capability.

The team was constituted force wide of 2 Detective Superintendents, 3 Detective Chief Inspectors, 6 Detective Inspectors, 9 Detective Sergeants and 4 Detective Constables. This team was expected to provide staff for key management roles in the MIRSAP structures for most significant enquiries. It was not expected to provide staff for enquiry teams, Family Liaison Officers and a range of other functions. These staff were drawn from across the force and worked in Divisions and Departments. The process for securing them for reactive enquires was generally one of negotiation with Divisional Commanders and Department Heads.

As one of the lead SIO's for the force I had no authority to deploy staff to any role other than in an immediate response to an incident. Any planned deployment of staff had to be under the authority of the Head of CID or the Assistant Chief Constable Specialist Operations.

I am clear in my mind that had the outcome of the meeting of the 21st May been an agreement to widen the scope of the Rochester investigation I would have had authority to draw upon force resources to support key areas.

The outcome of the meeting was no such agreement. Indeed a decision not to widen the scope of the investigation was the outcome. I therefore had no authority to conduct a widened investigation and implicitly no authority to use any resources other than those in the major crime team.

Quite specifically I must point out that Family Liaison Officers were resources out of my management control and that I did not believe I was mandated to deploy a significant number in support of particular activity associated with Operation Rochester.

It was my clear understanding that the enquiry would not be extended until a decision from the Crown Prosecution Service on the RICHARDS case had been made.

I should point out that I did have authority as an outcome of the meeting of the 21st May 2001 to scope and plan for a more extensive enquiry. The policy entries from the 21st May onwards therefore reflect that limited role and not a fully autonomous role as SIO with the authority to deploy staff from across the force to a management sanctioned enquiry.

I would invite others to consider the particular hindsight observations made in the report of Detective Chief Superintendent Johnston with the process and decisions made before I undertook SIO responsibilities for Operation Rochester, the decisions I took upon assuming that role and further take into account the very limited resources at my direct disposal.

Paragraph 36 makes observations about the Shipman case. The commentary in the report implies that I was criticising the local media for drawing parallels with the Shipman case whilst seeking the advice of those who had been engaged in managing the enquiry. There is no inconsistency, in my view, in this position.

I did think that it was irresponsible of the local media to characterise the Rochester enquiry as another Shipman case. There was no information which could support that assertion and it was, in my judgment, sensationalism likely to

create alarm and fear in the community. In making contact with those who had been involved in the Shipman case it was not in my mind that the potential criminal conduct mirrored that of Shipman himself. There was no evidence that it did.

There were parallels in terms of organisation, planning, issues with joint working with other agencies that were potentially valuable learning that it was considered useful to understand and consider in the context of the work being undertaken at that time. In my submission this is a different perspective on the Shipman issue than is reflected in the cited section of the report.

Paragraphs 37 to 39 correctly describe the concerns regarding Professor Livesley. My statement of the 31st January 2003 pages 12 to 17 describes this in some considerable detail. I reproduce for clarity key sections below which refer to a meeting with Senior Treasury Counsel on the 19th June 2001.

I recall that it was specifically put to him by Mr. PERRY that it therefore must be the case that his report was inaccurate, and more seriously, was misleading to both the Police, the Crown Prosecution Service and himself.

Professor LIVESLEY acknowledged that this was the only reasonable conclusion that could be drawn from the questions that had been put to him, his responses and the concessions that he had made.

I have previously observed that I was astonished at the responses that Professor LIVESLEY had been giving to the questions that had been asked of him about aspects of his report. My feelings and the conclusions I drew at the end of the questions that had been put to him by Mr. PERRY were exactly that. I was completely astonished that whilst on paper in his report Professor LIVESLEY had given all the appearances of being a competent, reliable expert under questioning he had simply collapsed. It was perfectly obvious his expert opinion and his report were deeply flawed.

He had an incomplete understanding of the law in relation to criminal liability in these cases, either in respect of the ingredients of the offence of murder or manslaughter gross negligence, he had inappropriately drawn conclusions about the criminal liability of key people as identified and he was unable to substantiate his assertion that Mrs. RICHARDS had died as a result of being knowingly over-prescribed a combination of drugs.

Most seriously he had conceded in the forum of the meeting that his analysis was flawed and founded on superficial understanding of the law and that in key areas of evidence his report was both inaccurate and misleading, not only to the Police but to the Crown Prosecution Service and to Senior Treasury Counsel. At the conclusion of the meeting Professor LIVESLEY was invited to make some further remarks but declined to do so and left immediately.

I remained with DCI CLARKE, Mr. CLOSE and Mr. PERRY to discuss the implications of the developments that we had all observed at the meeting.

It was clear to me, and the others at the meeting, that the responses Professor LIVESLEY had given to the questions that had been put to him had a devastating impact on the RICHARDS case.

Professor LIVESLEY had conceded that his report was inaccurate, unreliable and misleading and that the conclusions he had drawn about the criminal liability of the persons identified in his report were quite plainly wrong and that he could not identify any evidence to support the assertion that Gladys RICHARDS had been unlawfully killed.

The outcome of the meeting with Treasury Counsel, the Senior CPS Caseworker, Mr Close, DCI Clark and myself in relation to the Richards case was absolute.

It was as I have described in my previous statement and reproduced hereafter.

It was the view of all those present that the accumulative impact of Professor LIVESLEY'S responses to the questions that had been put to him fatally damaged the RICHARDS case. Whilst it was potentially an option to now secure the services of other experts who might comment upon the RICHARDS case as presented, what was immediately apparent was that Professor LIVESLEY'S inaccurate report and his verbal responses to the questions that had been put to him was disclosable information which could be properly categorised as that material which would undermine the prosecution case.

Mr. PERRY advanced the proposition that even if we were to secure other expert evidence that would support the original position that Professor LIVESLEY had taken, which he had now been forced to withdraw from, that there was no prospect of proceeding on the basis of any of the evidence that had been presented in relation to an allegation of the unlawful killing or murder of Gladys RICHARDS.

The principal reason for taking this position was the undermining nature of the evidence that would be released to the Defence that could be attributed to Professor LIVESLEY and the almost certain outcome that even if any contradictory evidence were to be presented, the Defence could simply call Professor LIVESLEY, ask him to present his original report, put to him all of those issues that he had now orally withdrawn during the course of the meeting and the case would inevitably fail. None of the persons present felt that that position could be contradicted.

There was a further fairly brief conversation during which Mr. PERRY and Mr. CLOSE indicated it was certainly their position that there was no evidence that could be used to support the prosecution of any person in relation to the death of Gladys RICHARDS. further that given the context of the interview with Professor LIVESLEY, they considered that there was no prospect of ever prosecuting anybody in relation to the death of Gladys RICHARDS even if further compelling evidence from experts was to be brought forward and that they would confirm this information to us in writing. DCI CLARK and I agreed with that position.

This was an unequivocal outcome. The Richards case had been examined by senior treasury counsel with experience of prosecuting in cases of gross negligence manslaughter in hospital settings and a clear decision made about the prospect of a successful prosecution.

The evidence that had been presented was deeply flawed, largely by the failure of the expert witness to come up to proof, and this had fatally damaged the prospect of ever launching a successful prosecution.

Of course the assumption that it fatally flawed any future prosecution was predicated on an assumption that fresh expert evidence could be uncovered. There were no grounds to suppose that this could be achieved.

Paragraph 40 refers to the decision to seek further reporting from other medical professionals. The first sentence refers to a "blow to the investigation".

In view of the comments I have made in relation to paragraph 39 I respectfully suggest that the capitulation of Professor Livesley at conference with counsel was more than a "blow to the investigation" for the reasons outlined.

The report authors state that:

"each of these relatives would have had a story to tell which would have provided the doctors considering the medical records with a better contextual understanding of the impact of the medical treatment provided to these unfortunate patients".

It is, in my submission, a matter of judgement as to whether or not the relatives' statements would have added value. In none of the dialogue with either Dr Mundy or Professor Ford did they request that information to assist their assessment.

I wrote to both Doctor Mundy and Professor Ford on the 15th August 2001 inviting them to provide a report on cases referred to them. The letters had attached

written terms of reference clearly articulating the nature of the issues they were to consider. The terms of reference make it very clear that the police are considering the prospect of some of those being involved in the care of those cases referred having some potential criminal liability.

Specifically the terms of reference state that both doctors were:

"To inform Detective Superintendent John James if there is other material or records which you require in pursuance of the above" (i.e. the terms of reference).

It is a matter of record that neither Doctor considered they required further information.

Had they asked for copies of statements from relatives, which they did not, I would have considered this request accordingly. However I must observe that I would not have responded positively to such a request without careful consideration.

I would argue that in many circumstances the provision of contextual information to expert witnesses may not be desirable. The function of expert witnesses is comment objectively on factual information. The contextualisation of the expert's opinion is a matter for the investigator and those involved in the court process. In considering the provision to an expert of contextual information I would always take into account the potential for that information to precipitate a conscious or unconscious bias in the final analysis of that expert.

It is a matter of record that Professor Ford produced an extremely thorough analysis in a 39 page report without having at his disposal statements from relatives as suggested.

I would further observe that the report again uses inappropriate language to describe a position. In paragraph 40 the use of the term "unfortunate patients" is not objective or necessary in the context of the commentary. It is an emotionally

loaded term that in my submission has no place in an independent review of this nature.

Paragraph 41 makes further reference to the issues of statements from relatives. I believe this is explained in considerable detail in my original statement in overall terms and specifically at page 52. I reproduce the relevant section below:

The fact that no statements were taken from family members was a tactical decision during the course of the investigation. It was my professional judgement, having reflected on all of the issues in the investigation, that without doubt the most critical issue that would determine the potential scope of a further investigation was the expert commentary available from the notes about the treatment that had been afforded each of the persons concerned. It was my professional judgement that the statements from family members would not add to the knowledge of the experts concerned. In my view they would only be able to comment about a chronology in respect of a patient's admission and their observations of care that was delivered which were not in themselves evidence that needed to be considered by an expert.

I believe that the fact that neither Professor Ford nor Doctor Mundy asked for statements as necessary further information to fulfil the obligations implicit in the terms of reference vindicates that tactical decision.

The report of Detective Chief Superintendent Johnston states that:

"There appears to be some organisational reason behind this reluctance, which in the view of the reviewing officer was a reluctance to expand the investigation into an area with significant resource and financial implications."

I have clearly set out the position in this and my previous statement and would re-emphasise that the decisions made in relation to statement taking I alone was responsible for making. I did not consult with any other senior manager or discuss the matter with any persons not a member of the major crime team.

The report author appears to me to be suggesting that there was some conspiracy between unidentified persons in the Constabulary to limit the scope of the Rochester investigation and by implication suggests that I was party to such a conspiracy.

I reject completely the proposition implicit in the commentary. No such agreement was in place.

I would submit that this suggestion is not indicative of an independent and objective assessment of the facts.

Paragraph 42 refers to the report author's belief that:

"it is at this point that the investigation begins to lean towards a civil remedy with the various medical bodies".

I challenge the report author to produce any evidence to support this assertion which is stated as a fact. This is, in my view, an interpretation of the material at the reviewing officer's disposal which is further indication of a lack of objectivity. Any enquiry of any person directly concerned in Operation Rochester from May 2001 to January 2002 would have provided information to the contrary. I am surprised no such enquiry appears to have been made.

My statement of the 31st January 2003 clearly outlines the rationale for engaging with the Commission for Health Improvement. I reproduce an extract from pages 23 and 24 below:

I subsequently met Dr. OLD on the 26th of June and briefed him about the broad position. We discussed what steps might be appropriate to engage any other agency that might have a responsibility for conducting enquiries into the general care that had been provided at Gosport War Memorial Hospital.

He indicated that this body was the Commission for Health Improvement, a body we had previously identified and I undertook to make contact with them direct to

discuss the general position. My reasoning in the circumstances was simple. The Police had been conducting enquiries about patient care at Gosport War Memorial Hospital for two years. Professor LIVESLEY had raised some general concerns in his report about the standard of care and it was unclear as to whether or not these practises were continuing. Whilst he was a completely unreliable source of expert information/evidence in relation to a criminal prosecution it would have been irresponsible to completely disregard his views. Whilst we were considering engaging the services of other experts it was my expectation that they would take some considerable time to report back to us, as indeed Professor LIVESLEY had. It appeared to me that we had a responsibility to draw to the attention of the appropriate groups or appropriate agencies Professor LIVESLEY'S report as it related to:

- *The general standard of care in order to determine whether or not those practises were continuing*
- *Whether or not potentially patients were at risk of receiving inappropriate treatment*
- *Whether or not there were concerns about the professional competence of persons delivering that care that fell short of them being considered to be criminally culpable*

The very significant lapse of time since the initial Police enquiry commenced led me to conclude that early contact with one of those agencies was absolutely imperative in order for them to assess whether or not it was appropriate to commence any enquiries about the standard of care being delivered at the hospital.

It was my intention to consider our position as soon as possible and seek to determine whether or not it was appropriate for an investigation by the police or other agencies to be conducted consecutively or concurrently with each investigation informing the other. I had reached no firm conclusions about the appropriateness of any particular course of action other than a need to make initial contact in the days immediately preceding the 25th of June.

The section I have underlined summarises the concerns that were in my mind and in particular the need to discuss with the relevant agencies as to whether or not they considered there were grounds for them to conduct their own investigations and whether or not it was appropriate for those enquiries to run parallel with a police enquiry or should follow the conclusion of any police enquiry.

Far from being a move towards civil remedy this action on my part was, in my submission, the actions of any responsible individual in possession of the information I have referred to.

My previous statement describes in very considerable detail the conduct of the investigation from June 2001 to January 2002.

I absolutely reject the suggestion that I was, as the SIO,

"leaning towards a civil remedy".

Such a suggestion lays the foundation for asserting that I was not conducting enquiries professionally and I do not accept this position. I believe that I acted professionally throughout my tenure as SIO for Operation Rochester.

Paragraph 43 builds upon the assertions contained in Paragraph 42. I absolutely reject the proposition that I was building an "exit strategy" from the investigation.

The report author suggests that the decision contained in policy decision number 30, dated the 9th August 2001, is evidence in support of this assertion. It is nothing of the kind. The rationale for that decision is clearly articulated in the full entry and in my submission it means exactly what is stated.

Paragraph 44 of Detective Chief Superintendent Johnston's report states that:

"the policy from this point (the CPS decision on Richards *) leans heavily towards justification for closing down the criminal investigation and passing the matter to the medical agencies".*

Paragraph 44 goes on to state:

"The reasons given are, in the view of the reviewing officer, spurious and untenable given the facts."

I take very particular personal exception to the suggestion in Detective Chief Superintendent Johnston's report to the judgement that the policy entries are spurious.

Spurious has a clear meaning in the english language, it means not genuine or fake. Given the clearly unambiguous meaning of the word I assume that is has been used deliberately in this context to convey the report author's judgment.

This commentary clearly suggests that in making entries in the policy book from June 2001 to February 2002 and in my original statement of the 31st January 2003 I have in fact lied.

This is the clearest possible attack on my personal and professional integrity and honesty that I absolutely reject. I do not believe that the reports author has any evidence to support this highly subjective and damaging assertion.

Indeed this assertion implies that in all my subsequent interactions with all other persons in relation to Operation Rochester, including those interactions with other members of the enquiry team, senior managers in the force, the Director for Public Health, Professor Ford and Doctor Mundy and senior staff at a key government agency, the Commission for Health Improvement, I was at best disingenuous and at worst deceitful in articulating the position and intentions of the constabulary in relation to any investigation.

In rejecting this assertion I would cite, as one example, clear and unequivocal evidence to the contrary that arises from my various interactions with the Commission for Health Improvement.

I first met the Operations Director and other key staff from the Commission for Health Improvement on the 20th July 2001. I outlined the nature of the investigations completed to date, the concerns about the current standards of care being delivered at Gosport War Memorial Hospital and the risks that sub-optimal care may present to future patients at the hospital.

Crucially I also briefed them that no decision had been made about the future scope and direction of any police enquiry and that any information and or evidence that they uncovered in their investigation would be disclosable to the police.

I pointed out that if they determined that an investigation was appropriate mechanisms would need to be put in place to pass information in a suitable format to the police enquiry team.

This non-negotiable position presented some difficulties for CHI. It was at that time a relatively immature organisation with limited experience of working with the police although it had real expertise in delivering on its core purpose. They were concerned that any investigation conducted by them should be impartial and their terms of reference explicitly focussed on organisational investigations and did not permit them to investigate at the individual level.

Specifically they had no experience of working with the police and felt that they needed to seek legal advice to determine whether or not in disclosing information they came into possession of during their investigations to the police they would be in breach of their legally constituted position. I recall later meeting solicitors advising the Commission to discuss this issue in more detail.

Notwithstanding these issues they indicated at that meeting that the information about events at Gosport War Memorial Hospital justified an enquiry. The

mandate for the investigation, the terms of reference and the interaction with the police investigation were therefore referred to the Board of the Commission for further approval. Subsequent to the meeting of the 20th July I had further dialogue with various persons at the commission as their decision making process developed.

On the 4th October 2001 the Commission agreed an investigation into care at Gosport War Memorial Hospital. The terms of reference are contained within their public report dated July 2002. Between the 4th October and the 17th October I had various exchanges with the force solicitor about the disclosure to CHI of information in the possession of the force about the investigation conducted to date by the police.

On the 22nd October the Commission announced their enquiry at a press conference in London. On the 23rd October I attended CHI's offices and discussed with the investigation manager, Julie Millar, the mechanisms by which they would identify and disclose information to the police that could be considered valuable to a criminal investigation.

On the 21st November I attended Gosport War Memorial Hospital and briefed the staff from CHI who were on site as part of the process of receiving information from the public and staff at the hospital. This was potentially a crucial period as it was possible that information would be revealed during interactions with CHI staff that was pertinent to a criminal investigation. I agreed with Julie Millar and a solicitor providing legal advice to the Commission a process for advising CHI staff how to deal with that information , how to contact the police and advice that could be given to members of the public or hospital staff who had pertinent information that could be made available to the police directly.

It is a matter of record that no such information became available during the course of their public consultation phase that was not already known to the police.

On the 7th January 2002 I met the team of specialists that had been put together by CHI to assist elements of the investigation at their hotel in Hampshire. This team is identified at page 2 of the Commission's report of July 2002.

One of the principal purposes of that meeting was to brief the investigation team on their personal responsibilities to disclose information that might reveal evidence of criminal liability by any individual. This was a comprehensive briefing and included relevant background information about the police investigation and key persons. In particular there was specific reference to Dr Barton, the GP who been responsible for the cases referred to Dr Mundy and Professor Ford.

I specifically recall that there was a conversation about the possible outcome of the police enquiry. I made it clear that no such decision had yet been made and there was a general conversation about the nature of the decision to be made and the scope, scale and direction of the police enquiry. I recall this clearly as a number of those present made remarks about the potential consequences of that decision and the difficulty of making a decision of this nature. I would expect that some or all of those present would have some recollection of that briefing.

I would also draw attention to a discrete element of CHI's investigation that is referred to as the "medical case note review" and is detailed at appendix E of CHI's report. This work was initiated as a result of conversations with Julie Millar, the investigation's manager, to ensure there was a further independent check of activity within the police enquiry. The same issues about disclosure to the police applied to this work which CHI communicated to the members of that review team.

Once CHI's field work was completed I was kept up to date about emerging findings in order to ensure that I was informed about developments and the publication of the report. This was particularly relevant to their recommendation number 24 concerning the development of protocols for information sharing in hospital investigations. No such protocols existed at the time as I have articulated in my statement of the 31st January 2003 at page 57.

The outcome of the work with CHI on this occasion contributed to the development of interagency protocols, I helped to draft the protocol between ACPO and CHI, and the development of a new section for the ACPO Murder Investigation Manual.

I refer to this detail about the interaction with the Commission for Health Improvement and key staff as I consider it is extremely relevant to my intentions whilst SIO for Operation Rochester.

If I was engaged in a planned withdrawal from a police investigation from as early as June 2001 I drew into an elaborate charade to mask that intention a significant number of persons from an independent government agency at considerable risk of my intentions being exposed at any time.

I was consistent in briefing these persons about their individual liability to disclose information to the police and the mechanisms for doing so in the event they identified issues of concern and delivered a number of personal briefings to people to that end.

A number of those persons, if asked, I am confident would support my recollection of events.

I submit that it is preposterous in the extreme to suggest that this consistent pattern of conduct over a period of 8 months involving the most senior staff in an independent government agency was indicative of an intention to withdraw the police from having any responsibility for events at Gosport War Memorial Hospital.

Paragraph 45 refers to policy decision number 42 dated the 28th January 2001 and states that the rationale described:

"are in fact a self fulfilling prophecy a decision having been made in June 2001 to close down the investigation as soon as possible."

I reject this assertion. No such decision had been made before that date. My statement clearly describes the process leading to the recording of that decision - policy decision 42 – and there is no evidence in the report of Detective Chief Superintendent Johnston that justifies the assertion made. I refer to my comments in respect of paragraph 44 in support of my position on this matter.

Commentary on the Conclusions

Paragraph 46 refers to the standards that the reviewing officer applied in making judgments about my conduct as SIO. There is no reference in this paragraph to the fact that no guidance was available to SIO's at that time on approaching investigation into deaths in hospital settings. This was recognised by the ACPO Homicide Working Group and such work was commissioned and was underway throughout late 2001 and early 2002. It later culminated in a further chapter for the ACPO Murder Manual.

Ironically this work was led by Detective Chief Superintendent Watts. I would add that I had a number of conversations with him about the challenges that the Rochester investigation presented and the need to ensure that advice, guidance, structures and processes were made available to future SIO's.

Paragraph 47 refers to the fact that no independent review of the investigation was conducted. Such a review would not have been my responsibility to initiate or complete. I am not aware of any Force Policy or Procedure that required me to arrange such a review or any policy or procedure that required such reviews in any investigation that were published guidance in the force at that time.

Paragraph 48 refers to what may have been the outcome of an independent review. Given that I would not have been responsible for conducting an independent review I believe it is inappropriate of me to speculate on its possible contents and recommendations.

Paragraph 49 refers to the deployment of Family Liaison Officers. I had no trained FLO's that were in my command who could be deployed. The decision of

ACC SO Smith on the 21st May 2001 to not authorise a widened investigation effectively meant that I had no authority to deploy FLO's. These are resources that were then under the command of Divisional Commanders and Department Heads and they could not be deployed on my authority alone.

I have articulated this information variously in this and my previous statement.

Paragraphs 50 to 52 refer to the management of the investigation. My clear position is that I was not authorised to conduct an investigation of the nature to which these criticisms refer.

I reject the suggestion that the investigative work I directed I lacked depth and quality. I believe I carried out adequate and reasonable enquiries given the constraints within which I was working as an outcome of the decision of the 21st May 2002.

Indeed I would argue that the steps that I took to engage the Commission for Health Improvement, the support I offered to that organisation and the efforts I made to ensure that there were clear protocols for exchanging information were professional and innovative in the circumstances. This was recognised by the commission and I am mentioned in the acknowledgements in their published report of July 2002.

Paragraph 53 refers to engagement with those persons who had contacted the police in April 2001 and states that there was no clear rationale for failing to engage with the families. My statement of 31st January 2003 provides a full explanation in relation to this matter.

In making a judgement about engaging with the families I was in the first instance, on assuming the role of SIO for Operation Rochester, guided and informed by the decision of DCI Burt on the 23rd April 2001 and the outcome of the meeting I convened on the 21st May 2001 to review the course of the enquiry. The outcome of that meeting and the constraints I believe were imposed upon me are described fully earlier in this statement.

Following the meeting of the 21st May I took urgent steps to consult with the Crown Prosecution Service and Treasury Counsel to understand the legal position on the Richards case which, it was agreed, was to be the benchmark for other potential investigations. These meetings were scheduled within 3 weeks of the meeting of the 21st May.

I considered, in all the circumstances, that postponing a decision about committing to a course of engagement with the families who had come forward in mid April was a reasonable step to take. I had every expectation that the meetings with the CPS and counsel would provide me with information on which to base recommendations and / or to make decisions about the future conduct of the enquiry.

The outcome of the meetings is adequately explained in this and my previous statement. It is sufficient to state that the outcome of the conferences with the CPS and Counsel was terminal to the Richards case and the credibility of the expert, Professor Livesley.

I believe that these outcomes left me in an extremely invidious position with no clear evidence to support an investigation of any scope.

I thereafter sought to secure further information from the cases submitted to Professor Ford and doctor Mundy as I have described. Securing that further information took considerably longer than expected.

I have previously acknowledged that it is a matter of considerable personal regret that I did not make arrangements for systems to be put in place to provide feedback to those who came forward in April 2001. I refer to the abstract below form my previous statement:

I believe that I have previously described the chronology of the decision making process in relation to the scope and scale of the ROCHESTER investigation earlier in this report and with the benefit of very considerable hindsight I believe

that in June and July 2001 I would have taken a series of different actions in relation to contact with the various persons who had communicated with us in 2001 I had conduct of the enquiry again.

I am not convinced, given the position that I found myself in at that time , that I would have sought to have sustained a whole series of contact through Police Officers in relation to those people.

What I would have sought to have done was to develop a model with all of the other interested parties in order to have a multi-agency forum that would have dealt with a whole range of concerns and communications issues with those relatives.

I think it is a matter of considerable personal regret that I did not develop such a model during that time which could have led to lines of communication opening up with all of those people which would not necessarily have compromised the position of the Force as I saw it at that time.

I have to say that there was no such model for me to follow for an enquiry of this type. Indeed there is a recognition that such a model needs to be developed nationally and work in this areas is in the process of finalisation. The absence of such a model that I could have developed for the investigation or that I could have been guided by may well have led to some shortfalls in terms of communication which has caused some anguish to those persons involved. I perfectly understand their general complaints in this regard and regret that I did not have the foresight to identify the issues concerned. However I should state that I genuinely considered myself to be acting in the neutral best interests of all the stakeholders in making the decisions articulated in this statement or on the investigation records.

In acknowledging, with the benefit of hindsight, that I could have made improvements to the arrangements with the families who reported concerns in April 2001 I do not accept, as suggested Detective Chief Superintendent

Johnston's report, that there was no rationale for failing to engage with them.

Paragraph 54 refers to the failure to investigate the complaints from the other families. I feel it is necessary to point out the context of those complaints. In April 2001 one case, that of Gladys Richards, had been referred to the CPS for consideration. The report that had been submitted to the CPS relied exclusively on the expert evidence provided by Professor Livesley to support the hypothesis that Gladys Richards had been unlawfully killed and that identified persons could be considered criminally liable in relation to her death.

The other persons who came forward in April 2001 were prompted to do so by a report in a local newspaper which was both inaccurate and misleading in relation to the police enquiries being conducted at that time.

It has always been my understanding that these other complaints were of the general standard of care afforded to those concerned and were prompted by sensationalist and inaccurate reporting in a local newspaper.

Given that Professor Livesley's expert evidence was crucial to the position in April 2001 I believe it is useful to draw attention again to my previous statement which describes the position at pages 15 to 19.

Specifically the following abstracts are relevant:

I was completely astonished that whilst on paper in his report Professor LIVESLEY had given all the appearances of being a competent, reliable expert under questioning he had simply collapsed. It was perfectly obvious his expert opinion and his report were deeply flawed.

He had an incomplete understanding of the law in relation to criminal liability in these cases, either in respect of the ingredients of the offence of murder or manslaughter gross negligence, he had inappropriately drawn conclusions about the criminal liability of key people as identified and he was unable to substantiate

his assertion that Mrs. RICHARDS had died as a result of being knowingly over-prescribed a combination of drugs.

Most seriously he had conceded in the forum of the meeting that his analysis was flawed and founded on superficial understanding of the law and that in key areas of evidence his report was both inaccurate and misleading, not only to the Police but to the Crown Prosecution Service and to Senior Treasury Counsel.

Further:

Professor LIVESLEY had conceded that his report was inaccurate, unreliable and misleading and that the conclusions he had drawn about the criminal liability of the persons identified in his report were quite plainly wrong and that he could not identify any evidence to support the assertion that Gladys RICHARDS had been unlawfully killed.

Finally:

What was absolutely and immediately apparent was that all of the previous decision making in the investigation had been predicated on the assumption that Professor LIVESLEY'S report was accurate in terms of its analysis and conclusions and that his professional opinion could be relied upon to inform the Police decision making in the context of the investigation.

Given the outcome of the meeting this was clearly not the case and that Professor LIVESLEY was not a reliable source of information professionally and that nothing that he had previously said could be relied upon to inform any future decision making.

More importantly, given that all of the previous decision making had been informed by his opinion and professional expertise, there was now a need to re-visit all the previous decision making.

In summary in late June 2001 the information then available to me as the SIO in relation to potentially unlawful deaths at Gosport War Memorial Hospital was the misleading and flawed report of an "expert witness" who had demonstrated an incomplete understanding of the law and whose credibility had been seriously undermined.

The concerns of those who had contacted the police, whilst potentially relevant, did not in my judgement provide a secure and rationale basis on which to commence an investigation of the nature and scope proposed.

The reports commissioned by Professor Ford and Doctor Mundy were later reviewed to understand if such a further investigation was warranted. It was my professional judgment that the contents of those reports did not reveal evidence of any criminal liability by any person engaged in the care of those patients as reviewed by those experts.

I had the advantage of having met with Senior CPS staff and Senior Treasury Counsel and was clear that there were a number of issues to consider in evaluating reports from these experts. I was confident that I understood the issues that could be extrapolated from the Richards case and applied to others to determine where they met thresholds in relation to potential criminal culpability.

The absolute first test was to evaluate whether or not the reports revealed a course of conduct by any doctor or nurse that had directly led to the death of an individual. A careful reading of both reports does not reveal such unequivocal judgments by either expert. On that basis the first test fails.

I am bound to state that I did not consider that there was value in further engaging the CPS and Treasury Counsel in confirming that position given my clear understanding from the earlier conferences and the inevitable delays that would result from submitting papers for their consideration. The Richards papers had been submitted in December 2000 and no official response had been received by June 2001.

I considered that it was my responsibility to evaluate the information at my disposal and make a clear decision. I did not think it was appropriate to arrive at a clear conclusion and then use a referral to the Crown Prosecution Service as means to quality assure my decision. This would, in my judgement, have been an abrogation of my responsibility as an SIO.

I reiterate my previous comments and reject the suggestion the decision was flawed.

Paragraph 55 refers to my being directed by some corporate entity. I absolutely refute this allegation.

Detective Chief Superintendent Johnston, states that is "clear" to him that I was being so directed whilst his report provides no evidence in support of this unequivocal finding. In my submission his conclusion is unsupported and is a further indication of an absence of an objective, dispassionate evaluation of the information reviewed.

Further in relation to Para 55 I re-emphasise the point that the decision of the 21st May 2001 placed limitations on my authority to act independently. Given clear instructions from the officer concerned I believe that, within those constraints, I acted professionally and diligently throughout.

Concluding remarks

In summary I would make the following observations about actions whilst SIO for Operation Rochester.

Between the 1st and 21st May 2001 I made preparations to assume responsibility for an investigation the conduct and direction of which had been previously determined by the previous SIO who had consulted at critical junctures with the then Head of CID.

I immediately set out to review the scope of the investigation culminating in a meeting on the 21st May of senior decision makers in the organisation including the Assistant Chief Constable Specialist Operations.

The outcome of that meeting was a clear decision not to extend the scope of the investigation at that time. I was mandated to:

- Explore the credentials of the expert on whom the enquiry at that time solely relied
- Determine the outcome of the CPS consideration of the Gladys Richards case
- Determine the role of any other regulatory body in investigating sub-optimal patient care at Gosport War Memorial Hospital

I believe that I discharged those clear directions professionally and diligently in the following 9 months.

I further believe that I did so giving due consideration to the need to act in the interests of persons who hade made contact with the police balanced against the need to ensure that the actions of the police did not undermine confidence in publicly provided health provision.

I am convinced that this was a legitimate balance given that I know there was a clear media agenda to characterise the police investigation in a sensationalist manner that I believed was at odds with the information available to me. Indeed I would argue that it was my duty to act responsibly in the circumstances.

I was concerned at each step to make objective evidence based decisions, properly considering the available information and determining the appropriate next steps. In discharging my responsibilities in this way it was necessary to carefully separate the emotional and necessarily subjective concerns of those not in possession of all the relevant information from the decision making process.

This is not a position that I took lightly and the consideration of the issues in this investigation presented me with very considerable personal and professional challenges.

Nevertheless I was prepared to accept that responsibility and discharge it rather than engage others when I judged that there was clear evidence to reach an informed decision. I believe that I acted professionally, responsibly and with integrity throughout my tenure as SIO for Operation Rochester.

I acknowledge, with the benefit of hindsight, that some aspects of the investigation fell short of the very high standards that I set for myself. I would assert that I was seeking to balance throughout my tenure as SIO a range of competing interests in a complex matter with, at times, inadequate information. There was no recognised guidance for investigations of this nature and I was making decisions based upon the best judgments at the time.

I would suggest that there is personal and organisational learning from every investigation and that this should be taken into account when considering the responses I have provided to the allegations made.

I would add that I have been engaged in major crime management in this force for 15 years. I have been engaged in duties as SIO variously since 1994. I believe that I have an exemplary record as an SIO in this force and that my professionalism in this role is acknowledged within the organisation.

I have to say that I am gravely concerned that the report I have responded to in this statement makes a series of judgments, unsupported by evidence, that very seriously undermines my professional reputation, my personal integrity and honesty.

My integrity and honesty are central to my sense of personal value and I am extremely disturbed that they have been undermined in a report which, in my submission, has not rationally and objectively evaluated the available information.